Patient Name: ______________________ Date: ______________

Date of collision: ____________ Time of collision: __________ AM/PM

City where collision occurred: ____________ Was the street wet or dry? WET/ DRY

Street (location) where collision occurred: ______________________

Who owns the vehicle in which you were hit? ______________________

What is the estimated repair damage to the vehicle? $________ Unknown/Estimate not done yet

How many people were in the vehicle at the time of the collision? __________

Did the police come to the accident scene? Yes/ no

Did the police make a written report? Yes/ No

Were any photographs taken of the vehicles? Yes/ No If yes, who took them? __________

DESCRIBE HOW THE COLLISION HAPPENED

____

____

____

____

____

____

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile collision you were involved in:

O	Single-vehicle collision		Two-vehicle collision	O	Three-or-more vehicles
O	Rear-end collision	O	Side collision	O	Rollover
O	Head-on collision	O	Hit guard rail, tree, or object	O	Ran off the road
O Other (Describe):					

Circle your seating position:

Front of vehicle

1	2	3
4	5	6
7	8	9

Rear of vehicle

DESCRIBE THE VEHICLE YOU WERE IN If not certain, check unknown:

Model, Make, and Year: O Unknown

DESCRIBE THE OTHER VEHICLE If not certain, check unknown:

Model, Make, and Year: O Unknown

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

O	Slowing down	O	Gaining speed
O	Stopped	O	Moving at a constant or steady speed

AT THE TIME OF IMPACT, THE OTHER VEHICLE WAS:

O	Slowing down	O	Gaining Speed	O	Unknown speed
O	Stopped	O	Moving at steady speed	O	Other:

DURNG AND AFTER THE COLLISION, YOUR VEHICLE:

O	Kept going straight, not hitting anything	O	Spun around, not hitting anything
	Kept going straight, hitting car in front	O	Spun around, hitting another car
O	Was hit by another vehicle	O	Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the bod regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with another vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK ANY OF THE FOLLOWING THAT WERE DAMAGED:

O Windshield	O	Seat bent or damaged	O	Dash or area around knee/foot
O Steering wheel	O	Side or rear window broken	O	Other
Describe Damage:				

ALL TYPES OF COLLISIONS Please indicate those relevant to your case.

YES	NO	
		Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the collision?
		Did the side door, dash, or interior of our vehicle touch or hit your body during the collision?
		Did you strike or did any objects or animals within your vehicle hit you during the collision?
		Were the doors of our vehicle damaged to a point where you could not enter the door?
		Did an air bag deploy in our vehicle during the collision? If yes, circle side airbag front airbag)
		Did you have any cuts, bruises, or abrasions from the airbag deploying?
		Did your seatbelt system require repairs after the collision?
		Was the seat that you were sitting in damaged or bent during the collision?
		If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
		Were you wearing a seatbelt? If yes, does your seatbelt have A. Lap and Shoulder Strap, B. Automatic shoulder strap with driver needing to manually attach the lap belt, C. Lap belt only
		Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
		Did you have any cuts, bruises, or abrasions from the seatbelts?
		Were you holding onto the steering wheel (driver only) at the time of impact? If yes, indicate where each hand was positioned (Use a time clock face as your reference point) Left hand: O Not on wheel, O Yes, hand at _____ o'clock, O Hand elsewhere Right hand: O Not on wheel, O Yes, hand at_____ o'clock, O Hand elsewhere

REAR-END COLLISIONS ONLY

Describe your vehicle's head restraint system:

O Movable/adjustable head restraint O Fixed, non-moveable head restraint

O No headrests in my vehicle O Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of collision (if present):

O At the top of the back of your head O Midway height of the back of your head

O Lower height of the back of your head O Located at the level of your neck

O Level of your shoulder blades

BRUISING AFTER THE COLLISION?

YES	NO	
		Did your body have any bruising (areas that were visibly black, red, and/or blue) after the collision? If yes, indicate where bruising was located on your body and what caused the bruising (if known): ____

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
	You were aware of the impending collision and relaxed before the collision.
	You were aware of the impending collision and braced yourself.
	Your body, torso and head were facing straight ahead.
	You had your head and/or torso turned at the time of collision: D Turned to left, Tumed to right Describe how far you were turned /twisted and why you were tumed/what were you doing?
	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
	Your torso/bod were positioned normally against the seatback with no gaps due to leaning / twisting.

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

Excessive fatigue-malaise	Bowel or bladder disorders	Night pain or night time sweats
Weight loss	Ovarian pain	Abdominal pain
Low grade fever	Kidney pain/ painful urination	Balance problems

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

I have no history of previous painful injury or pain If you have had prior injuries or pain lease check below:

O Work Injury	O Fall	O Sports Injury	O Lifting Injury	O Car Accident
O Motorcycle Injury	O Head Injury	O Pedestrian Injury	O Military Injury	O Other Injury
O Headaches/Migraines	O Neck Pain	O Middle Back Pain	O Low Back Pain	O Shoulder Pain
O Arm numb-tingling	O Arm Pain	O Leg pain-numb-tingling	Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(O I have never had any broken bones.) If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
O Spinal Vertebra		O Skull	
O Collar bone clavicle		O Rib bone	
O Arm or hand bones		O Leg or foot bones	
O Pelvis or hip bones		O Other: ____________________	

PREVIOUS SURGERIES

(O I have never had any surgical procedure). If you have had any previous surgeries, indicate where and when:

Surgery	Year	Surgery	Year
O Spine Surgery neck, back, or pelvis		O Appendix or stomach	
O Disc surgery in neck or back		O Gallbladder/Stomach/ Kidney	
O Heart		O Cancer (any type)	
O Head/Brain		O Hernia in (inguinal or hiatal)	
O Shoulder/Arm/Hip /Leg		O Other	

ARE YOU TAKING ANY MEDICATIONS?

O I am not taking any medications currently. Check an of the following that you are taking currently.

O Muscle Relaxants	O Blood pressure/Stroke prevention medications	O Cortisone injections
O Pain/Anti-inflammation meds	D Osteoporosis (bone strengthening medications)	O Other:

HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE COLLISION?

____

____

LIST ALL SYMPTOM REGIONS RELATED TO YOUR MOTOR VEHICLE COLLISION

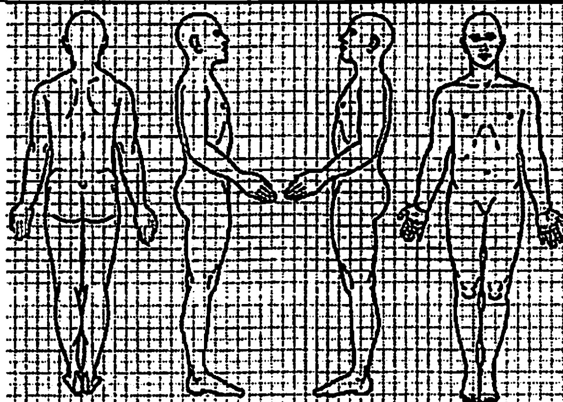
CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
O Headaches/Migraines		O Upper Back Pain, Soreness, or Stiffness	
O Neck Pain, Soreness, or Stiffness		O Hip Pain	
O Low Back Pain, Soreness, Stiffness		O Leg or Foot Pain, Numbness, or Tingling	
O Arm/Hand Pain, Numbness, or Tingling		O Knee/Ankle Pain	
O Shoulder/Elbow/Wrist Pain		O Dizziness / Vertigo	
O Jaw Pain		O Swelling Stiffness of Joints	
O Excessive Fatigue		O Other:	

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

No Pain (0) — Unbearable Pain (10)

SYMPTOM/PAIN DESCRIPTION (Please circle any words/areas below that describe your current symptoms.)

Pain	Pinching	Spreading	Stiff or tight	Unbearable
Shooting	Soreness	Pulling	Sickening	Falls asleep
Achy	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Pressing	Radiating
Heavy	Nagging	Stinging	Deep pain	Weakness
Irritating	Burning-Hot	Dreadful	Superficial pain	Throbbing
Exhausting	Numbness	Torturing	Sharp	Tender



Please circle or mark with an X the areas where you have pain, numbness, tingling or other symptoms.

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

Morning is when pain is worse	Bending your back increases pain	Walking increases pain
Afternoon/evening pain worse	Lying down flat increases pain	Standing increases pain
During sleep hours pain worse	Sitting increases pain	Exercise/Stretching increases pain
Standing u from sitting	Poor posture increases pain	Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

O Walking	O Being Flat on your back	O Exercise/ stretching
O Sitting	O Standing	O Other:

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST PRESENT
	Heal slowly or Bruise Easily	
	Smoke cigarettes or use tobacco products	
	History of drug or alcohol abuse	
	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	
	Heart attack or have a heart pacemaker or neck or chest shunt?	
	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc.	
	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	
	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	
	Epilepsy -Seizure-Convulsion history or other neurological disease	
	History of multiple sclerosis, lupus, psoriasis, temporal paralysis, or meningitis	
	Cancer history or cancer treatment of any type	
	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	
	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	
	Told that you have a bulging / herniated disc, or disc degeneration in the spine	
	Have you ever been hospitalized? Why?	
	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurism	
	Hypertension or high blood pressure	
	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	
	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	
	Do you have any type of chest or breast implants presently (males & females)?	

Women only: Is there any chance that you are currently pregnant? Yes / No

Do you have any problems lying face down on an examination table? Yes/ No
If yes, why: ____________________
Have you ever been to a Chiropractor before for any condition? Yes / No
If yes, Chiropractor's Name : ____________________ Year: ____________________
Please Print Patient Name: ____________________

____________________ ____________________
Signature of Patient or Patient Guardian Date